BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
125 S. Main Avenue
Sioux Falls, SD 57104
http://medicine.sd.gov SDBMOE@state.sd.us

Dear Doctor:

If you have ever held a license to practice medicine or osteopathy in South Dakota at any point in the past, **do not** attempt to apply using this process as that license was forfeited by statute. If you wish to reinstate and then renew such a license, please email sdbmoe@state.sd.us or otherwise contact the Board office in writing for instruction and be aware that this can be a lengthy process.

To reduce the possibility of a need to withdraw or have an application denied, determine if you meet the following statutory South Dakota eligibility requirements by answering the following questions:

1. Did you successfully complete an ACGME accredited training program of at least three years in the United States or Canada?
2. Did you have a 75% or greater score on all sections of one of the following licensing examinations?
   USMLE, FLEX, NBME, NBOME/COMLEX, LMCC or state exam
3. Have you passed each part of your licensing examinations in three attempts or less?
4. Are there less than seven years from the initial examination to the final examination?
5. If you are an international or foreign graduate, are you ECFMG certified?

If you answered "NO" to any of the above questions, you are not eligible for South Dakota licensure, unless you are board certified by the American Board of Medical Specialties (ABMS).

Note: the Board strongly suggests that applicants not make commitments to start practicing medicine in South Dakota until a license is issued. Some applicants make commitments to start work at a certain time and later find that the commitment can not be kept. Every applicant has unique history and the Board can not promise that an application will be processed in any given amount of time. The speed with which applications are processed depends on how quickly applicant initiated information arrives and the completion of a background investigation. Communication regarding the application shall be in writing and directly between the Board and the applicant.

The information contained herein is vital to the successful completion of you application and timely consideration of your request for licensure. Please use the instructions and checklist to complete this application. The application process will be delayed by the following factors, including but not limited to: illegibility, incomplete or inaccurate information, failure to enclose the required fee and documents, failure to arrange for the required applicant initiated primary source verifications, failure to answer all questions completely and accurately. If you have questions about the application or attached forms, please email sdbmoe@state.sd.us or otherwise contact this office in writing before you return your application.

If you receive this application from a source other than directly from this office or its official website, the application may be outdated or not an official version. To ensure you have the official version please contact this office. Application forms will be rejected if not on the current version.

The Federation Credentials Verification Service (FCVS):

The Board highly recommends, but does not require, the use of FCVS to primary source verify core physician credentials as part of the licensure process. If using FCVS, the Board recommends completing the FCVS application first or simultaneously with the South Dakota Board of Medical and Osteopathic Examiners Licensure Application.

FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to help license portability for physicians. FSMB is a national not-for-profit organization that provides this service for state medical and osteopathic medical licensing authorities in the United States., Guam, Puerto Rico and the Virgin Islands, (contact FCVS for a complete state listing of requiring and accepting licensing authorities).

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies and stores for you fall into the following categories:

- Identity
- Medical Education
- Postgraduate Training
- Examination History (state licensing authorities only)
- Board Action/Disciplinary History
- ECFMG Certification (if applicable)
- ABMS Board Certification

You pay FCVS a fee for gathering and forwarding your Initial or Subsequent Profile, and can also forward additional Profiles to other licensing boards and health care entities of your choice. Average processing time to collect and forward your initial Profile is approximately 8-12 weeks. Once your permanent file is established, updated Subsequent Profiles are typically forwarded within 2-3 weeks. Most physicians will benefit greatly throughout their career by having their credentials permanently stored and easily accessible.

Contact FCVS at 888-ASK-FCVS (or outside the U.S. at 1-817- 868-5000) for additional information regarding the service and its fees. If your credentials are already on file with FCVS, contact FCVS directly at the above number to have them forwarded to the South Dakota Board of Medical and Osteopathic Examiners.

Common License Application Form (CLAF):

The Board has incorporated the Common License Application Form (CLAF) into its Medical Licensing Application. This form will make it easier for physicians to apply for licensure in states that utilize this form (CLAF). The South Dakota Board of Medical and Osteopathic Examiners is one of the growing number of boards to incorporate the CLAF into its state license application.

If you have questions about our process of the information provided to you in the application packet, please email our office at sdbmoe@state.sd.us . Thank you for your interest in applying for licensure in the State of South Dakota.

Instructions for completing the South Dakota Board of Medical and Osteopathic Examiners Licensure Application

Application Fees. Enclose the $200 fee. The fee is non-refundable and any application received without the appropriate fee attached will be returned.

Examination Transcript. Request that a transcript of your exam scores be sent directly to the South Dakota Board of Medical and Osteopathic Examiners from the appropriate examining agency. For those that have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), you must request the transcripts from the NMBE.
If you are using FCVS, they will obtain your exam score transcripts based on the information you provide in the FCVS application.

- USMLE/FLEX – Request transcripts online at www.fsmb.org or call (817)868-4000.
- NBME – Download the request form at www.nbme.org/pdf/endorse.pdf or call (215)590-9500.
- NBOME/COMLEX – Download the request form at www.nbome.org or call (773)714-0622.
- State Exam – Contact the state licensing board in which you took the exam.
- LMCC – Call (613)521-6012.

ECFMG (if applicable). Request that a Record of Scores of ECFMG Certification be sent directly to the South Dakota Board of Medical and Osteopathic Examiners from the ECFMG. **If you are using FCVS, you do not need to contact the ECFMG. You will complete the ECFMG release forms included in the FCVS application and FCVS will coordinate with the ECFMG to obtain your certification.**

- ECFMG – download the request form at www.ecfmg.org/cvs/forms/282asb.pdf or call (215)386-5900.

Application Instructions. The application and attachments should be printed legibly in Blue or Non-Black ink, or preferably, electronically typed and generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application.

Complete the application as instructed in each section. Please see below for additional instructions on completing the application and additional documents that need to be submitted to the board.

Additional Instructions – please see below additional instructions for completing specific sections of the Common License Application Form (CLAF).

- Chronology of Activities (Section 10, Pages 8 and 9)
  - When listing activities, LEAVE NO GAPS IN CHRONOLOGY.
  - Submit Addendum 2 to any entity where you held privileges, were employed or practiced.
  - If the practice or organization is no longer open, attach a separate sheet listing name, address, and phone number of someone who can verify your time there.
  - If you left any practice or organization under any condition, other than voluntary, please attach a separate sheet listing the condition under which you left.

Additional Documents - submit the following documents to the Board (if applicable):

- Copy(ies) of current Board Certification.
- Curriculum Vitae
- Malpractice Claims Information (Section 11, Page 10)
  - After completing this section, attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e. statement from an attorney, court records, etc.) of your response.

Addendum Instructions. Complete the addenda as instructed below. If additional space is necessary, please attach a separate sheet and reference the question being answered.

Addendum 1 (Page 1). Please complete entirely. Date and sign the bottom.

Addendum 2 (Pages 2 and 3). Sign and date the authorization and then send this form to each entity where you held privileges, were employed or practiced as listed in Section 10 of this application.

Addendum 3 (Pages 4 and 5). These questions must be completed by the applicant. Please provide a complete and signed explanation for any affirmative answers on a separate sheet. Date and sign the bottom.

Addendum 4 (Page 6). Fee Payment Information. Check or credit card options. Date and sign the bottom.

Final Addendum (Pages Y and Z). Read the entire release form. Date and sign the bottom.

The original completed application, attached documents and appropriate licensure fees must be sent to the following address:

South Dakota Board of Medical and Osteopathic Examiners
125 South Main Avenue
Sioux Falls, SD 57104

List of Specialties

AMA Self Designation of Specialties	AMA
Allergy	A
Adolescent Medicine (Pediatrics)	ADL
AddictionMedicine	ADM
Addiction Psychiatry	ADP
Allergy & Immunology	AI
Clinical Laboratory Immunology	ALI
Aerospace Medicine	AM
Adolescent Medicine (Internal Medicine)	AMI
Anesthesiology	AN
PainManagement(Anesthesiology)	APM
Abdominal Radiology	AR
Abdominal Surgery	AS
Anatomic Pathology	ATP
BloodBanking/TransfusionMedicine	BBK
ClinicalBiochemicalGenetics	CBG
Critical Care Medicine (Anesthesiology)	CCA
Clinical Cytogenetics	CCG
Critical Care Medicine (Internal Medicine)	CCM
Pediatric Critical Care Medicine	CCP
Surgical Critical Care (Surgery)	CCS
Cardiovascular Disease	CD
Craniofacial Surgery	CFS
Clinical Genetics	CG
ChildNeurology	CHN
Child and Adolescent Psychiatry	CHP
ClinicalPathology	CLP
Clinical Molecular Genetics	CMG
ClinicalNeurophysiology	CN
Colon & Rectal Surgery	CRS
Cardiothoracic Surgery	CTS
Dermatology	D
Developmental-Behavioral Pediatrics	DBP
Clinical and Laboratory Dermatological Immunology	DDL
Diabetes	DIA
Dermatopathology	DMP
Diagnostic Radiology	DR
Dermatologic Surgery	DS
Emergency Medicine	EM
Endocrinology, Diabetes and Metabolism	END
Epidemiology	EP
Sports Medicine (Emergency Medicine)	ESM
MedicalToxicology(EmergencyMedicine)	ETX
Forensic Pathology	FOP
FamilyPractice	FP
Geriatric Medicine (Family Practice)	FPG
FacialPlasticSurgery	FPS
Sports Medicine (Family Practice)	FSM
Gastroenterology	GE
Gynecological Oncology	GO
General Practice	GP
General Preventive Medicine	GPM
General Surgery	GS
Gynecology	GYN
Hematology (Internal Medicine)	HEM
Hepatology	HEP
Hematology (Pathology)	HMP
Head & Neck Surgery	HNS
Hospitalist	HOS
HandSurgery	HS
Interventional Cardiology	IC
ClinicalCardiacElectrophysiology	ICE
InfectiousDisease	ID
Immunology	IG
Clinical and Laboratory Immunology (Internal Medicine)	ILI
Internal Medicine	IM
Geriatric Medicine (Internal Medicine)	IMG
Sports Medicine (Internal Medicine)	ISM
Legal Medicine	LM
Medical Management	MDM
Maternal & Fetal Medicine	MFM
Medical Genetics	MG
Molecular Genetic Path (Med Genetics)	MGG
Molecular Genetic Path (Pathology)	MGP
Medical Microbiology	MM
InternalMedicine/Pediatrics	MPD
Public Health & General Preventive Medicine	MPH
Musculoskeletal Radiology	MSR
Neurology	N
Neurodevelopmental Disabilities (Psych)	NDN
NeurodevelopmentalDisabilities(Ped)	NDP
Nephrology	NEP
Nuclear Medicine	NM
Neuropathology	NP
Neonatal-Perinatal Medicine	NPM
Hematology/Oncology	OH

AMA Self Designation of Specialties	AMA
Nuclear Radiology	NR
Neurology/Diagnostic Neurology/Neuroradiology	NRN
Neurological Surgery	NS
Pediatric Surgery (Neurology)	NSP
Nutrition	NTR
AdultReconstructive Orthopedics	OAR
Obstetrics-Gynecology	OBG
Obstetrics	OBS
Critical Care Medicine (Obstetrics & Gynecology)	OCC
FootandAnkle Orthopedics	OFA
Occupational Medicine	OM
Other	OS
OsteopathicManipulativeMedicine	OMM
Musculoskeletal Oncology	OMO
Medical Oncology	ON
PediatricOrthopedics	OP
Ophthalmology	OPH
Orthopedic Surgery	ORS
Sports Medicine (Orthopedic Surgery)	OSM
Orthopedic Surgery of the Spine	OSS
Otology/Neurotology	OT
Otolaryngology	OTO
Orthopedic Trauma	OTR
Psychiatry	P
ClinicalPharmacology	PA
Pediatric Anesthesiology	PAN
PulmonaryCriticalCare Medicine	PCC
Chemical Pathology	PCH
Cytopathology	PCP
Pediatrics	PD
Pediatric Allergy	PDA
Pediatric Cardiology	PDC
Pediatric Endocrinology	PDE
PediatricInfectiousDisease	PDI
Pediatric Otolaryngology	PDO
Pediatric Cardiothoracic Surgery	PCS
Pediatric Pulmonology	PDP
Pediatric Radiology	PDR
Pediatric Surgery	PDS
Medical Toxicology (Pediatrics)	PDT
Pediatric Emergency Medicine (Emergency Medicine)	PE
Pediatric EmergencyMedicine (Pediatrics)	PEM
Forensic Psychiatry	PFP
Pediatric Gastroenterology	PG
PediatricHematology-Oncology	PHO
Pharmaceutical Medicine	PHM
Clinical and Laboratory Immunology (Pediatrics)	PLI
PalliativeMedicine	PLM
Physical Medicine & Rehabilitation	PM
Pain Management	PMD
PediatricNephrology	PN
Pediatric Ophthalmology	PO
Pediatric Pathology	PP
Pediatric Rheumatology	PPR
Pain Management (Physical Med & Rehab)	PMR
Plastic Surgery	PS
Sports Medicine (Pediatrics)	PSM
Anatomic/Clinical Pathology	PTH
Medical Toxicology (Preventative Medicine)	PTX
PulmonaryDiseases	PUL
Sports Medicine (Physical Med & Rehab)	PMM
Psychoanalysis	PYA
Geriatric Psychiatry	PYG
Radiology	R
Reproductive Endocrinology	REN
Rheumatology	RHU
Pediatric Rehabilitation Medicine	PRM
Neuroradiology	RNR
Radiation Oncology	RO
Radiological Physics	RP
SpinalCordInjury	SCI
Sleep Medicine	SM
Surgical Oncology	SO
Selective Pathology	SP
Trauma Surgery	TRS
Transplant Surgery	TTS
Urology	U
Undersea Medicine	UM
Pediatric Urology	UP
Plastic Surgery with the Head and Neck	PSH
Thoracic Surgery	TS
Unspecified	US
Vascular and Interventional Radiology	VIR
Vascular Medicine	VM
General Vascular Surgery	VS

Application for Physician Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service and one when you are not using FCVS. Please use the checklist that applies to you.

	State does not require FCVS and you choose not to use FCVS	State requires or accepts FCVS and you are using FCVS
Completed Application (including state addendums)	☐	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐	☐
Notarized copy of birth certificate or current, valid passport	☐	completed via FCVS
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Medical school transcripts sent to the Board by your medical school	☐	completed via FCVS
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended	☐	completed via FCVS
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	☐	completed via FCVS
Examination transcripts sent to the Board	☐	completed via FCVS
ECFMG (if applicable) Status Report sent to the Board	☐	completed via FCVS

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

M.D. ☐ D.O. ☐

_____

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

/ /

Date of Birth (mm/dd/yyyy) | Birth City | Birth State/Province | Birth Country

Gender | Social Security Number | NPI Number | Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

1. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

Applicant Name: _____ Date: _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name _____

Hospital Address _____

City _____

State/Province _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other _____

Department/Specialty: _____

From: / To: / Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

2.Hospital Name _____

Hospital Address _____

City _____

State/Province _____

ZIP Code _____

Country _____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other _____

Department/Specialty: _____

From: / To: / Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

Applicant Name: _____ Date: _____

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ____/____ To: ____/____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State	_____	☐ P ☐ F	_____
FLEX Pre-1985	_____	☐ P ☐ F	_____
FLEX Component 1	_____	☐ P ☐ F	_____
FLEX Component 2	_____	☐ P ☐ F	_____
LMCC – Single	_____	☐ P ☐ F	_____
LMCC – Part I	_____	☐ P ☐ F	_____
LMCC – Part II	_____	☐ P ☐ F	_____
NBME Part I	_____	☐ P ☐ F	_____
NBME Part II	_____	☐ P ☐ F	_____
NBME Part III	_____	☐ P ☐ F	_____
SPEX	_____	☐ P ☐ F	_____
NBOME Part I	_____	☐ P ☐ F	_____
NBOME Part II	_____	☐ P ☐ F	_____
NBOME Part III	_____	☐ P ☐ F	_____
COMLEX Level 1	_____	☐ P ☐ F	_____
COMLEX Level 2	_____	☐ P ☐ F	_____
COMLEX Level 3	_____	☐ P ☐ F	_____
COMVEX	_____	☐ P ☐ F	_____
USMLE Step I	_____	☐ P ☐ F	_____
USMLE Step II	_____	☐ P ☐ F	_____
USMLE Step III	_____	☐ P ☐ F	_____

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

2. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

3. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

4. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

5. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

6. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

7. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

8. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

9. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

10.State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

Applicant Name: _____ Date: _____

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

11. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other _____

Amount of judgement or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: _____ Date: _____

Licensure Verification Form **Form #1**

(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: _____

Address: _____
Street City State/Province ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date: _____

Is this license current? ☐ Yes ☐ No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Applicant Name: _____ Date: _____

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____ First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date _____

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: _____

Address _____ City _____ State/Province _____ ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____

Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From _____ To _____ Graduation Date: _____ Degree: _____

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized)

Title: _____

Date: _____

Phone number: _____ Fax: _____

E-mail: _____

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☐ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response ☐YES ☐NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
☐ Academic Probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason		

Please specify reason: _____

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Postgraduate Training Verification - Page 2 of 3

(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: _____

Institution Address: _____

Street _____

City _____

State/Province _____

ZIP Code _____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year: _____

☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Chief Resident

Other: _____

From Date: _____/_____/_____ To Date: _____/_____/_____

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☐ No
Was this individual ever placed on probation?	☐ Yes	☐ No
Was this individual ever disciplined or placed under investigation?	☐ Yes	☐ No
Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☐ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☐ No

Please explain any “Yes” response from above (attach additional pages if necessary): _____

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____

Fax: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From _____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE

Title: _____

Date: _____

Phone number: _____

ADDENDUM 1

1. Local Home Address: Please report your local, South Dakota, home address if different from your current home address reported on the CLAF (Section 2, Page 1).

   _____

   _____

2. Proposed South Dakota Practice:

   Practice Name: _____

   Practice Address: _____

   _____

   Phone: _____ Fax: _____

   Primary Specialty: _____ Subspecialty: _____

   Specialty/Subspecialty in which care will be provided: _____

3. Specialty/Subspecialty Certification: Refer to "List of Specialties" link when completing this section

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

   If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failure of written or oral exams, if any.

   _____

   _____

   _____

4. **D**rug **E**nforcement **A**dministration Registration:

   DEA Number: _____ State: _____ Exp. Date: _____/_____/_____

   Approved for all schedules? ☐ Yes ☐ No, please explain:

   _____

   _____

   If you do not maintain a DEA certificate, please explain:

   ☐ Not applicable to practice.

   ☐ DEA certificate pending. Date application submitted: _____/_____/_____

   ☐ Other:_____

Print Name of Applicant: _____ Date: _____

Signature: _____

ADDENDUM 2 – Page 1 of 2

(Copy this form as needed)

Verification of Professional Privileges and/or Employment

Have each facility where you worked and practiced complete this form and return it to this office. **PLEASE BE AWARE THAT THIS FORM MUST BE COMPLETED BY THE FACILITY WHERE YOU ACTUALLY PRACTICED NOT A CONTRACTING OR PLACEMENT AGENCY BECAUSE SOUTH DAKOTA REQUIRES PRIMARY SOURCE VERIFICATION.**

Therefore, this form shall be completed by all professional employers, clinics or hospitals.

To be completed by the applicant:

Dates of Employment: From: _____ To: _____
(MM/DD/YY) (MM/DD/YY)

Name of Current or Previous Facility: _____

Address of Current or Previous Facility: _____

_____

This is your authorization to release information regarding my privileges and/or employment in your files, favorable or otherwise, directly to: South Dakota Board of Medical and Osteopathic Examiners

_____

(Use BLUE INK: Applicant Signature and Date)

_____

(PRINT Applicant Name and Date)

Below filled out by Facility ONLY: (Please explain "YES" answers on a separate sheet)

1. Have you ever known of poor medical practice by this individual or have you discussed concerns about this individual's practice with medical staff officers or others? ☐ Yes ☐ No
2. Have there been reports of poor relationships between this individual and other members of the hospital staff, patients, or the public? ☐ Yes ☐ No
3. Are you aware of any derogatory information related to the individual's ability to practice medicine? ☐ Yes ☐ No
4. Are you aware of any mental, physical, emotional or personal problems this individual may have that might interfere with his/her practice of medicine? ☐ Yes ☐ No
5. Has this individual ever abused drugs or alcohol? ☐ Yes ☐ No
6. Has this individual ever shown any signs of chemical dependence? ☐ Yes ☐ No
7. Are you aware of any limitations, restrictions, or any other actions of any nature taken against the individual by a hospital, managed care entity, or any other health-related entity or organization, state or federal including medical academic institutions? ☐ Yes ☐ No
8. Does this individual accept hospital policies and function accordingly? ☐ Yes ☐ No
9. Has this individual ever taken a leave of absence or break from your facility for any reason and for any length of time? ☐ Yes ☐ No

ADDENDUM 2 – Page 2 of 2
(Copy this form as needed)

Conditions under which employment ended (Voluntary or Other):

_____

_____

_____

If Other, explain:

_____

_____

_____

Derogatory Information, if any:

_____

_____

_____

Comments, if any:

_____

_____

_____

Signature:
(Signature Stamp Not Acceptable) _____

Print Name: _____

Direct Phone Number: _____

Title: _____

Date: _____

DO NOT FAX – attach additional sheets if needed
MAIL COMPLETED FORM TO:
SDBMOE
125 S. MAIN AVENUE
SIOUX FALLS, SD 57104

ADDENDUM 3 – Page 1 of 2

ANSWER THE FOLLOWING QUESTIONS. **For any "YES" responses, please provide a complete, signed and dated explanation.**

Professional Questions.

Have you, your license or an application for license, whether formally or informally, whether voluntarily or involuntarily:

1. been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, not renewed by, withdrawn or relinquished to any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ☐ No ☐

2. been subject to proceedings or investigations by a licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization to terminate, stipulate, restrict, limit, withdraw condition, reprimand, suspend, revoke, refuse, deny, relinquish, or not renew your professional license? Yes ☐ No ☐

3. appeared or been requested to appear before any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization concerning any violation by you of any law, rule, or regulation of any state, district, territory or province of the United States, Canada, or other country? Yes ☐ No ☐

4. been subject to proceedings or investigations (for any reason) by any medical facility or professional society, group, or organization to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, relinquish, withdraw or not renew membership? Yes ☐ No ☐

5. been notified of a complaint by a medical facility or professional society, group or organization, or any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization? Yes ☐ No ☐

6. been dishonorably discharged from a branch of the United States military or National Guard? Yes ☐ No ☐

7. had your membership, participation, clinical privileges, request for privileges or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, withdrawn or relinquished to or not renewed by any peer review committee or organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization? Yes ☐ No ☐
   Is there a review pending? Yes ☐ No ☐

8. been reprimanded, censured or disciplined by, or been subject to a corrective action agreement/plan with any licensing or disciplinary board, agency or committee, health-related entity, governmental agency or organization, peer review organization, professional assistance program, third party payer, clinic, hospital, or medical staff? Yes ☐ No ☐

9. had your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, relinquished, withdrawn or not renewed, or is any investigation or proceeding with respect to any such action presently underway? Yes ☐ No ☐

10. been charged by complaint, information, indictment, or otherwise, of any felony or misdemeanor, other than a minor traffic violation? Yes ☐ No ☐

11. plead guilty, or plead no contest to, any felony or misdemeanor, other than a minor traffic violation? Yes ☐ No ☐

12. been convicted of, or received a suspended imposition of sentence or suspended sentence of any kind, to a felony or misdemeanor, other than a minor traffic violation? Yes ☐ No ☐

13. been accused of or been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive or discriminatory behavior? Yes ☐ No ☐

14. been reported to the NPDB (National Practitioners Data Bank) or HIPDB (Healthcare Integrity and Protection Data Bank) for any reason? Yes ☐ No ☐

15. had any cases, whether criminal, civil or administrative (of any kind of description), been brought against you or received notice of intent to do so? Yes ☐ No ☐

16. had any judgments been entered against you in professional liability cases? Yes ☐ No ☐

17. had any final judgments or malpractice claims paid by you? Yes ☐ No ☐

18. had any final judgments or settlements or malpractice claims been paid on your behalf by another entity? Yes ☐ No ☐

19. are there any malpractice challenges pending against you at this time? (Including any pending claims, lawsuits, judgments, and/or settlements.) Yes ☐ No ☐

20. Has any liability insurance carrier cancelled your coverage? Yes ☐ No ☐

21. Have you been denied coverage or been rated at a higher than average risk class for your specialty? Yes ☐ No ☐

22. Has your carrier excluded any specific procedures from your insurance coverage? Yes ☐ No ☐

Health Disclosure Questions.

1. Do you have a physical, mental or emotional condition which would preclude you from performing the essential functions of your practice? Yes ☐ No ☐

2. Have you ever been treated, hospitalized or confined for any Mental Health issue, including but not Limited to: Acute Stress Disorder, Anxiety or Mood Disorder, Bipolar Disorder, Major Depressive Disorder (recurrent or single episode), Obsessive-Compulsive Disorder, Alcoholism or Alcohol Abuse or Drug Use? **(If yes, please provide letter from treating physician along with your explanation)** Yes ☐ No ☐

3. To the best of your knowledge, information or belief, has any person or entity ever reported or suggested to you, or as a result of a self-evaluation, have you concluded that your use of alcohol or drugs has affected your ability to provide appropriate care to patients or to otherwise perform the usual and necessary functions of you medical practice without posing a health risk to your patients? Yes ☐ No ☐

4. Are you currently using illegal drugs or prescription controlled medications in an illegal manner? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) Yes ☐ No ☐

5. Have you used illegal drugs within the last two years? "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) Yes ☐ No ☐

Print Name of Applicant: _____ Date: _____

Signature: _____

ADDENDUM 4

I enclose the following fee(s):

- ☐ $200 for Physician License
- ☐ $50 for Locum Tenens Certificate
- ☐ $50 for Resident Certificate: only available for a physician who has completed PGY1 and is currently in good standing within an ACGME (Accreditation Council for Graduate Medical Education) accredited residency
- ☐ $50 for Resident Training Permit: available for a physician currently in good standing within an ACGME (Accreditation Council for Graduate Medical Education) accredited residency; PGY1 and beyond

Make check payable to: SDBMOE

or

Complete below for credit card:

Credit Card Number: _____

Expiration Date: _____

Print Name of person signing credit card: _____

Signature _____ Date _____

Print Name of Applicant: _____ Date: _____

Signature: _____

HIPAA Authorization

I am aware of the Health Insurance Portability and Accountability Act of 1996 (thereinafter called HIPAA) and understand the provisions dealing with the privacy of my medical records. With such knowledge an understanding, I agree to the following:

a. I do hereby authorize the use or disclosure of my health information by the South Dakota Board of Medical & Osteopathic Examiners (SDBMOE), for purposes of licensure in the state of South Dakota.

b. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and hospitals, and treatment for alcohol and drug abuse.

I further release, discharge and exonerate all third parties or person(s) from any and all claims, damages, and liabilities of any nature, who in good faith and without malice, release the HIPAA information to the SDBMOE.

Authorization and Release

Any references to the terms "Users" or "Users of this Application" in this authorization shall include the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners together with its board members, staff members, legal counsels, investigators, agents, employees, contractees, and authorized representatives hereinafter collectively referred to as SDBMOE;
2. Any other state or national medical licensing, medical reporting or medical regulatory board;
3. The Federation of State Medical Boards;
4 Any other South Dakota or United States agency in furtherance of and incompliance with SDBMOE's duties and responsibilities under the South Dakota Medical Practices Act and its administrative regulations.

I am the person described herein. I have not engaged in any acts prohibited by the criminal or medical statutes of the State of South Dakota. I am the person named on any diploma or certificated that I have received, I am the lawful holder of said diploma or certificate, and the diploma or certificate was given to me in the regular course of instruction and examination without fraud or misrepresentation.

The following deals with SDBMOE consulting with and receiving information from third parties:

I authorize SDBMOE to consult with any third person or party who may have information or evidence concerning my professional, ethical, mental and physical qualifications, or any other matter that SDBMOE deems relevant regarding my continuing qualifications for licensure with SDBMOE. These third persons and parties include hospitals, institutions or organizations, my references, physicians, therapists, previous and present employers, past and present business and professional associates, and local, state, federal or foreign governmental agencies and instrumentalities, courts of any jurisdiction, associations, institutions or law enforcement agencies, together with their representatives thereof, who have custody or control of any documents, records, information or evidence that SDBMOE deems relevant to my Application.

I authorize such third persons and parties to unconditionally release to SDBMOE any such information, including documents, records regarding charges or complaints filed against me, formal, or informal, pending or closed, or any other pertinent data or evidence whether favorable or unfavorable that SDBMOE deems relevant to licensure, and to permit the SDBMOE to inspect, receive, and make copies of such documents, records, evidence, and other information for SDBMOE's evaluation of my professional, ethical, mental and physical qualifications that SDBMOE deems relevant to licensure.

I release, discharge and exonerate from any and all claims, damages and liabilities whatsoever such third persons and parties, together with their authorized representatives, who in good faith and without malice, consult with and release to SDBMOE such information, evidence, files or records requested by SDBMOE that SDBMOE deems relevant to licensure.

I declare and affirm under the penalties of perjury that:

This application for licensure, which includes all the information I have provided and the questions I have answered in the South Dakota Common License Application Form and Addenda thereto, have been examined by me, and to the best of my knowledge and belief, are in all things true and correct. I state unconditionally and without reservation that I absolutely understand each and every question contained in this application for licensure, that I and I have answered all of them completely and truthfully. If any user discovers any derogatory information regarding my personal background that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I agree that such non-disclosure shall disqualify me for licensure in South Dakota.

I understand and agree that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the SDBMOE may consider all such actions in its determination whether to grant licensure. To that end, I agree that any unprofessional or harassing behavior on my part, or on the part of any agent of mine, with the SDBMOE's members or staff shall establish grounds for the immediate cessation of all processing of this application and disqualify me for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the SDBMOE, and I will not assert that any other entity, judicial, or otherwise, may make such determination. I understand and agree that cessation of processing of this application by the users as a result of the acts of omissions by myself as described in this paragraph shall not require the SDBMOE or any other users of this application, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing or any other due process rights, or any other statutory or constitutional rights that I may enjoy pursuant to SDCL 1-26, SDCL 36-4, the South Dakota Constitution, or the United States Constitution. I hereby waive any and all due process rights and any other statutory or constitutional rights that I may enjoy as it relates to all matters described above and in any manner related to this application.

Print Name of Applicant: _____ Date: _____

Signature: _____